AIDS Brief

For sectoral planners and managers

Health Sector

The health sector is unique in that it is at once affected by the HIV/AIDS epidemic and is also the sector with the major responsibility for dealing with the epidemic, both in terms of preventing new infections and in caring for people with HIV/AIDS. Other ministries and sectors have been content to view the epidemic as a problem for the Ministry of Health, typically one of the weaker and less well funded ministries. Economic crises and structural adjustment policies have affected the level and funding of health activities as well as other social services, and thus may have created conditions which favour the spread of HIV while weakening the ability to respond.

Even in the health sector itself the response has been complicated by the nature of HIV/AIDS: it is largely sexually transmitted, which means there is a stigma attached; and it potentially uses considerable resources, but patients die despite the best efforts of health professionals, which has an adverse effect on morale. Due to the long incubation period, even in situations where seroprevalence levels appear to have peaked, the number of AIDS cases will continue to grow for some years to come. The health sector has to respond in a dynamic and flexible way.

Definition

The health sector comprises government health facilities; private commercial facilities and practitioners, including medical, paramedical, and drug sellers of various kinds; private non-profit facilities and practitioners; and traditional medical practitioners. Each is involved in HIV / AIDS-related activities to some degree. This AIDS Brief relates primarily to the concerns of the public health sector, but is also relevant to the other actors.

Typically, public health care in developing countries will be provided at various levels. At the lowest level are health posts and clinics (primary health care facilities), staffed by nurses and midwives; the next level is the health centres with some beds, offering intermediate health care, and staffed by one or more doctors. Above this are the regional hospitals, and finally the main referral and specialist hospitals. At the lower levels health staff combine curative and preventative health care activities, and if the system is to operate in a cost-effective and efficient manner the bulk of the patients should be seen and treated here.

Key Elements

Providing effective health care within resource constraints

At present the main burden of HIV disease often falls on secondary and tertiary hospitals, causing displacement and deterioration of care for other patients. This is because at the primary health care level staff are often trained in counselling patients with HIV, but not in the basic care the patients need. Staff may therefore believe that care of patients with HIV-related disease is the responsibility of the hospital, resulting in a tendency to refer patients upwards at the first suspicion of HIV infection.

Insufficient attention is directed to the needs of people in the earlier stages of HIV infection. Much life-prolonging and life-enhancing care can be provided, and emphasis should be placed on maintaining “wellness”. The overburdening of hospitals can be alleviated by using all levels of the primary health care system and by effective planning for care, including provision of drugs required at lower levels of the health system. Effective care at health centre level can be provided using treatment protocols for common conditions and providing basic essential, inexpensive drugs. Where HIV testing possibilities are limited, health staff need not feel an HIV test result is essential for routine health care for people with HIV/AIDS.

Hospitals and health services are having to cope with a doubling or even tripling of TB patients, involving much greater demands of diagnostic services, outpatient short-course therapy, directly observed treatment, and emphasis on improving patient adherence to treatment. It is essential to plan for this rapid expansion of cases to avoid drug

shortages and disruption to treatment. Health centres can play an important role in TB treatment, especially in overseeing and supporting the patient during the maintenance phase. In situations where the health sector includes private, public, non-governmental, religious and other groupings, there may be an opportunity to allocate responsibility for different levels of care, or at least to co-ordinate it.

In many countries home-based care has been seen as a cost-effective way of providing for patients outside the formal health sector. Some of these programmes have been very costly, relying on expensive vehicles and salary incentives for staff, with little expenditure actually benefiting the patients. Home-based care can be effective in terms of patient needs and reduced costs, but it must be based on an assessment of what actual needs are, then be organised to meet those needs. For example, the opportunity should be taken to provide information and basic training to carers before a patient is discharged. In the wealthier countries there may be a hospice movement to care for the dying, and they can be involved in dealing with the epidemic.

The inevitability of death has to be faced, and in heavily affected countries additional provision of mortuary space is essential. In some countries the laws do not facilitate patients dying quietly at home, but encourage families to rush dying patients to hospital so the cause of death may be certified more easily without police involvement. This is stressful for staff and patients, and is not a good use of hospital resources. Changes in death certification would allow patients to die comfortably at home.

Labour

The health sector is one of the most labour-intensive services. HIV is reducing the effectiveness of the health labour force in several ways.

Stress and "burnout" among health workers

Around the world health workers caring for people with HIV/AIDS experience greater stress than other health workers. Causes include fear of contracting HIV from patient contact, social contamination (ostracism and stigma of working with people with AIDS), discomfort with the sexual dimensions of HIV/AIDS, and a sense of professional inadequacy due to high levels of patient mortality. They also experience "role expansion", being asked to undertake tasks for which they are not prepared, such as advocacy and counselling. This is particularly stressful when patients and staff are from the same community (or even the same health facility) and may know each other well. They may also have difficulty dealing with patients' emotional traumas. In some cases the opposite may be true - health staff may dislike or feel a great social distance from patients or clients, such as commercial sex workers and patients with STIs. They may have religious, moral, or cultural objections to the advice they are expected to give, e.g. concerning the use of condoms or sexual behaviour.

HIV/AIDS coincides with diminution of resources in drugs, supplies etc.; front-line health staff are often blamed for shortcomings of the system. Proposed solutions include developing a team spirit and ethos; orientation programmes for new staff; training in coping skills, stress management, psychological aspects of dying, bereavement, relationships with dying patients, peer support and sharing of feelings; and participation in decision-making.

Ethical issues

Health staff may feel ill-equipped to face some of the ethical dilemmas posed by the HIV epidemic. In most societies they are expected to keep HIV results confidential, yet they may find this difficult if they know someone is repeatedly exposing others to HIV via unprotected sex. A further issue is the problem of displacement of non-HIV infected patients; resources are scarce and balance is required between the needs of all patients, yet they find it difficult to discharge a patient for whom little can be done.

Training compels health staff to do their best for each patient, yet this may be neither compatible with the needs of all patients, nor in the interest of the individual patient. Health staff may face pressure from families or colleagues to provide "heroic" care for dying patients. Even lower-level ward staff often have to make difficult decisions, when for example two patients simultaneously need the only oxygen cylinder available. Staff may face pressure for referrals to tertiary care or even abroad and have difficulty deciding what is "fair", especially when referrals would use public funds, or the additional care is clearly futile.

The solution to these issues is twofold: firstly, open discussion where staff can exchange views and decide what care is within their powers to provide; and secondly, establishing treatment protocols for the most common complications, not only in planning for the availability of drugs but also in deciding what is reasonable care.

Mortality and absenteeism of health staff

Health staff themselves are being affected by HIV infection. In some countries very high levels of HIV seroprevalence have been recorded among health workers. A pilot study in Zambia found that mortality among female nurses had risen 13-fold from 1980 to 1991 to 2.67% and appeared in 1994 to have risen to 4%. Absenteeism had also risen, from about 10% to about 15%.

Doctors, laboratory technicians, and other health workers are also heavily affected in some countries; re-

ports indicate that some health professionals continue to take great personal risks, feeling somehow protected by their profession and education. Others so fear HIV that they are leaving the health profession or migrating to areas where the perceived risk is lower. Little evidence exists to prove or disprove any link with occupational exposure, but early studies show no association between HIV infection among health staff and exposure to patients.

Solutions to the problem of HIV among health staff would include providing better information and education about risks, both personal and professional, and reinforcing and adhering to safety procedures and provision of adequate protective equipment for high-risk tasks (e.g. long gloves for deliveries). HIV-positive staff are particularly vulnerable to exposure to TB; if staff are known to be HIV-positive, they ought not be asked to care for TB patients. In some countries better provisions are required to replace staff who are ill for a long period, to avoid the problem of "ghost workers" who are officially in service but unavailable for work. Further research is necessary on the contribution of occupational and personal risk to the high levels of HIV observed among health staff.

Training and replacement of health staff

High levels of mortality and absenteeism have profound effects on the health services. Whilst demands on the service are greater than ever, any expansion in training new staff is constrained by losses of appropriately trained teaching staff. Health ministries will need to consider ways to retain existing staff (raising the retirement age, improving service conditions, improving public perception of health care work etc.); increase the supply of staff through expansion of training schemes; and possibly maximise staff effectiveness by e.g. harnessing family members for basic nursing tasks, reducing time spent on paperwork, creating new cadres of staff to take on some basic nursing, and using all levels of the health system.

Co-ordination and funding issues

The HIV epidemic has engendered a world-wide mobilisation of funds and interest, which may cause problems for the health sector due to the influx of new NGOs, researchers, and donor agencies wanting to do AIDS-related work. They require co-ordination from the usually understaffed health sector; may have their own priorities and objectives; tend to work in isolation from and even in competition with the government and each other; and may attract health sector staff away by offering better salaries.

The influx of funds may cause problems: it may not suit local priorities or existing structures. Jealousies and problems may arise concerning allocation of per diem allowances, travel, and opportunities for international exposure. The efforts to comply with donor accounting and reporting procedures may exceed the value of the support.

The solution to these problems lies in better communication. A co-ordinating council, and regular meetings at all levels, would reduce duplication of effort and gaps in provision, and provide an opportunity to share information and approaches. Donor agencies must be made aware of the problems their policies create. Researchers must ensure their work is reviewed by local ethics committees, and findings are made available locally as soon as possible.

The roles of the private and traditional sectors

Long-established missions and private sector practitioners may also be perceived as competing with the government, both for patient loyalty and trained staff. Private sector practitioners may in fact be working at cross-purposes, providing costly and / or sub-standard treatment for TB or for STIs and thus facilitating the further spread of the latter.

The traditional sector has also been active in provision of care for AIDS patients, and while in many cases this has been helpful to patients and has helped hospitals by diverting some of the care, in other cases the promise of a "cure" has lured patients who could have been helped away from standard care, which is especially important in treating TB. In addition, the private and traditional sectors charge for their services - which may have long-term consequences for household resources. In some instances a service such as condom provision may not, for various reasons, be provided, leaving a potential gap in health promotion.

The solution is to improve communications - to ensure that practitioners are at least aware of national treatment guidelines and have a clear idea of the role they can play. Both groups are usually organised through an association or other grouping, and might be willing to be brought into a dialogue about their role in treating HIV and related conditions. Training could also involve the pharmacists, etc. who provide the drugs widely used in self-care.

Sectoral Response

The HIV epidemic reveals and exploits weaknesses in the health sector. In several countries HIV seroprevalence now doubles every 12 months or so, and its ability to spread rapidly before illness appears makes it

particularly dangerous to disorganised societies, with limited ability to believe the epidemic is happening and to take effective action. This is why this AIDS Brief emphasises communication and open discussion of the many issues HIV raises for the health sector: HIV thrives best in conditions of secrecy, stigma, and denial.

☑ Checklist

Problem	***Proposed solution***
❍ Health staff stress and burnout	❍ Open discussion on concerns of staff ❍ Training in coping and stress management ❍ Participation in decision-making
❍ Ethical dilemmas for health staff	❍ Open discussion of issues, case studies or specific examples ❍ Treatment protocols setting standards of reasonable care
❍ Mortality and absenteeism of health staff	❍ Better information on personal risks ❍ Adherence to safety procedures and provision of protective equipment ❍ HIV-positive staff not to care for TB patients
❍ Training and replacement of staff	❍ Retain existing staff: improve public image of health professions, improve conditions of work, raise retirement age ❍ Increase supply of staff: expand training places, create new lower-level cadre to do routine tasks ❍ Improve effectiveness of staff: involve family members, reduce paper-work, use all levels of health service ❍ Improve procedures to cope with long-term illness among key staff
❍ Provision of effective health care within resource constraints	❍ Use all levels of the health services ❍ Provide drugs and training especially at primary health centre level ❍ Plan for expected rise in TB cases, and involve health centres ❍ Emphasise "wellness" of people with HIV ❍ Target home-based care on needs and those most in need ❍ Facilitate peaceful death at home and provide adequate mortuary space
❍ Co-ordination of donors and funding agencies	❍ Discuss priorities with donors ❍ Discuss reporting and accounting needs with funding agencies ❍ Hold regular co-ordination meetings
❍ Co-ordination with private and traditional sectors	❍ Contact professional associations, discuss issues of interest ❍ Provide training, especially in STI and TB treatment ❍ Train drug sellers and other informal providers in use of basic drugs

Useful References

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